



# Student Accident & Sickness Insurance CLAIM FILING INSTRUCTIONS

## FOR PARENTS, LEGAL GUARDIANS AND CLAIMANTS OF LEGAL AGE



### Coverage terms and conditions

Prior to an injury or sickness occurring or as soon as possible thereafter, please familiarize yourself with the terms and conditions of coverage including: what activities are covered; benefits; exclusions; requirements and limitations; important deadlines, etc. These may be found in policies on file with school/parish authorities, printed brochures used to secure coverage, online or by contacting us directly at (800) 827-4695.



### Obtaining a claim form

If unavailable through your child's school/parish, you may obtain a claim form directly from us by calling (800) 827-4695 or by requesting via email at [claims@myers-stevens.com](mailto:claims@myers-stevens.com) or by faxing (949) 348-2630 or (949) 348-9350.



### Completing claim forms either during

#### REGULAR SCHOOL SESSIONS

- Report school/parish related injuries immediately to school officials, providing as much detail as possible.
- Request a Student Accident & Sickness Insurance claim form from the school/parish and ask an authorized school/parish official to COMPLETELY AND LEGIBLY fill out Part A of the form. If the reported injury is not school/parish-related, you may fill out Part A yourself. Only one claim form is required per injury or condition.
- COMPLETELY AND LEGIBLY fill out Part B (missing fields will cause delays) provide signatures where requested, date and return to our office along with your itemized bills and Explanations of Benefits (EOBs) from any other applicable insurance or health plan.

OR

#### COVID-MANDATED SCHOOL CLOSURES / DISTANCE LEARNING

- **For students enrolled on a voluntary-purchase basis for a) Full-Time 24/7 Accident and/or b) Dental Accident and/or c) Student Accident & Sickness and/or d) Worldwide Exchange** - Parents/legal guardians and students of legal age may complete and sign Part A on their own, providing as much information as they can. Reporting to school officials if school related is encouraged but not required. Complete the rest of the form, sign and return per instructions on the form.
- **For students enrolled on a voluntary-purchase basis for School-Time and/or tackle football related injuries only** - Immediately report school related injuries using remote contact instructions provided by your school/district if applicable. Complete Part A as fully as possible, providing all the same information given to the school/parish including the name and title of the school official the injury was reported to. Complete the rest of the form, sign and return per instructions on the form. Our Claims staff will follow up through our established school/district contacts to verify information provided.
- **For students from schools/parishes that purchase coverage on a blanket basis** - Immediately report school/parish related injuries or other covered losses to the school/parish using the remote contact instructions provided by your school/parish if applicable. Complete Part A as fully as possible, providing all the same information given to the school/parish including the name and title of the official the injury/loss was reported to. Complete the rest of the form, sign and return per instructions on the form. In addition to helping us verify circumstances surrounding a reported loss, please know that we rely on the school/parish to confirm that the claimant is an enrolled student. Our Claims staff will follow up through our established school/parish contacts to verify information provided.

**IMPORTANT** – All fields must be legibly completed and signatures provided where requested or processing will be delayed!



### Finding a health provider

You are free to take your child to any properly licensed health provider but out-of-pocket costs may be reduced if you seek care from providers who are contracted under the *First Health Network* or *First Choice Health Network* (WA only). Contracted providers may be found at [www.firsthealth.com](http://www.firsthealth.com) (800) 226-5116 or [www.fchn.com](http://www.fchn.com) (800) 231-6935. If your child also has coverage through an HMO, please know that benefits under many of our school/parish-paid blanket plans may be reduced if you seek out-of-network services that are not preauthorized by your HMO. This potential benefit limitation does not apply to any of our individually purchased plans and does not apply to emergency care.



### When treatment is sought

- Give the provider's billing/admissions person your primary insurance/health plan information (if applicable).
- If you purchased one of our individual plans for your child, present your student insurance ID Card. If your child is covered under a blanket plan that is paid for by the school/parish, let the billing person know that and identify the district, Diocese or other school system involved and the specific school/parish. In either case, explain that your child has medical expense insurance that provides benefits on an excess or secondary basis and that it is NOT what is sometimes referred to as "third party" insurance. Your child is the insured.
- Ask the billing person to add Myers-Stevens & Toohy into their system as a payor and to either send us the itemized bills described above directly (preferred!) or to send you those same bills to be forwarded to us. Letting the provider know that you are assigning benefits to them may help smooth the process. If you have difficulty, please contact us and we'll be happy to help.



### If your child has other insurance or health coverage

File a claim with that primary plan (except Medicaid) and send us copies of their "Explanation of Benefits" or "EOBs" once processed.



### What we need from the providers who see your child\*

In order to evaluate your claim and provide benefits, we will need fully itemized bills from any providers seen. These are known as HCFA 1500 or CMS 1500 forms from providers such as doctors and as a UB04 form from facilities such as hospitals and surgery centers. They contain the following required information:

- Date(s) of Service
- Billed Charges
- Diagnostic Codes - these tell us what is wrong with your child
- Procedural or Revenue Codes - these tell us what was done to evaluate/treat the problem
- Provider Tax ID Number - needed to issue W-9s when benefits are assigned to providers
- National Provider Identifier (NPI) - needed to comply with Federal regulations

**NOTE** – we are not able to use "statements" from providers, primary health plan EOBs or a receipt of payment in lieu of the required itemized billings as described above.

*\*If you have Kaiser, request "courtesy statements" from Kaiser Member Services that include the information listed above. Please make sure the documentation submitted indicates what portion of the charges, if any, you are obligated to pay out of your own pocket.*



### Final Steps

Send: 1) Completed claim form; 2) Itemized bills; 3) Other insurance/health plan EOBs (when applicable) to:

**MYERS-STEVENS & TOOHEY**  
Attn: Claims Department  
26101 Marguerite Parkway  
Mission Viejo, CA. 92692

OR

Fax: (949) 348-9350

OR

Email: [claimsinfo@myers-stevens.com](mailto:claimsinfo@myers-stevens.com)

# STUDENT ACCIDENT & SICKNESS INSURANCE CLAIM FORM

|  |       |   |                |   |  |  |                                |
|--|-------|---|----------------|---|--|--|--------------------------------|
| <b>PART A</b>  |       | <b>SCHOOL/PARISH STATEMENT</b>                  |                | (Parent, legal guardian or claimant of legal age may complete Part A if injury is not school/parish-related or if injury is sustained during COVID-related distance learning at home) |  |  |                                |
| NAME OF CLAIMANT   | FIRST | MI  | LAST           | AGE   | GRADE  | <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE  | DATE OF BIRTH<br>MO / DAY / YR |
| ADDRESS OF CLAIMANT  |       | CITY  |                | STATE   |  | ZIP CODE   |                                |
| IS THE CLAIMANT A:<br><input type="checkbox"/> STUDENT <input type="checkbox"/> STAFF <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> OTHER _____  |       |   |                | ID # FROM ID CARD (if applicable)   |  |  |                                |
| NAME OF SCHOOL/PARISH  |       |   |                | NAME OF DISTRICT, DIOCESE OR OTHER SCHOOL SYSTEM  |  |  |                                |
| SCHOOL/PARISH MAILING ADDRESS  |       | CITY  |                | STATE   |  | ZIP CODE   |                                |
| DURING WHAT ACTIVITY DID THE INJURY OCCUR? <input type="checkbox"/> INTERSCHOLASTIC PRACTICE <input type="checkbox"/> INTERSCHOLASTIC GAME <input type="checkbox"/> P.E. <input type="checkbox"/> CLASSROOM <input type="checkbox"/> PLAYGROUND <input type="checkbox"/> TRAVEL <input type="checkbox"/> AT HOME <input type="checkbox"/> FIELD TRIP<br><input type="checkbox"/> RELIGIOUS EDUCATION <input type="checkbox"/> CONFIRMATION <input type="checkbox"/> YOUTH MINISTRY <input type="checkbox"/> YOUNG ADULT MINISTRY <input type="checkbox"/> CYO <input type="checkbox"/> PAL <input type="checkbox"/> OTHER _____  |       |   |                |   |  |  |                                |
| WAS THE CLAIMANT PARTICIPATING IN A SPORT NOT SCHOOL/PARISH-SPONSORED AND SUPERVISED? <input type="checkbox"/> YES <input type="checkbox"/> NO   |       |   | TYPE OF SPORT: |   | DOES THE SCHOOL/PARISH HAVE ANY RECORD OF ANY HEALTH COVERAGE FOR THE CLAIMANT? <input type="checkbox"/> YES <input type="checkbox"/> NO |  |                                |
| IF YES, LIST NAME OF SPORTS ORGANIZATION:  |       |   |                |   | If YES, name of plan:  |  |                                |
| DATE OF INJURY/SICKNESS<br>MO / DAY / YR   |       | TIME OF INJURY<br>: A.M. / P.M.<br>(CIRCLE ONE) |                | WHAT PART OF THE BODY WAS INJURED?<br><input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT  |  | HAS THE CLAIMANT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE?<br><input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHEN? |                                |
| PROVIDE DETAILS ON HOW AND WHERE THE INJURY OR ILLNESS OCCURRED. PLEASE BE SPECIFIC  |       |   |                |   |  |  |                                |
| NAME AND TITLE OF SUPERVISING OFFICIAL AT TIME OF INJURY   |       |   |                | WAS HE/SHE A WITNESS TO THE ACCIDENT?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | DATE SCHOOL/PARISH WAS NOTIFIED<br>/ /   |                                |
| <b>NAME AND TITLE OF SCHOOL OFFICIAL INJURY WAS REPORTED TO</b>  |       |   |                | SIGNATURE<br><b>X</b>   |  | DATE SIGNED  |                                |
|  |       |   |                |   |  | SCHOOL/PARISH TELEPHONE NUMBER<br>( )  |                                |
| <b>PART B</b>  |       | <b>PARENT OR LEGAL GUARDIAN INFORMATION</b>     |                |   |  |  |                                |
| NAME OF CLAIMANT'S PRIMARY PHYSICIAN   |       |   | ADDRESS        |   |  | PHONE NUMBER<br>( )  |                                |
| IS THE CLAIMANT COVERED, DIRECTLY AND/OR AS A DEPENDENT UNDER ANY OTHER INSURANCE OR HEALTH PLAN(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO  |       |   |                |   |  | POLICY NUMBER(S)   |                                |
| IF YES, NAME OF PLAN(S)  |       |   |                |   |  |  |                                |
| NAME OF CLAIMANT'S EMPLOYER (if applicable)  |       |   | ADDRESS        |   |  | PHONE NUMBER<br>( )  |                                |
| <b>NAME OF FATHER OR LEGAL MALE GUARDIAN</b>   |       |   |                | MOBILE TELEPHONE NO.<br>( )   |  | HOME TELEPHONE NO.<br>( )  |                                |
| ADDRESS  |       | CITY  |                | STATE   |  | ZIP CODE   |                                |
| NAME OF EMPLOYER <input type="checkbox"/> Self Employed <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed   |       |   |                |   | WORK TELEPHONE<br>( )  |  |                                |
| ADDRESS OF EMPLOYER  |       | CITY  |                | STATE   |  | ZIP CODE   |                                |
| <b>NAME OF MOTHER OR LEGAL FEMALE GUARDIAN</b>   |       |   |                | MOBILE TELEPHONE NO.<br>( )   |  | HOME TELEPHONE NO.<br>( )  |                                |
| ADDRESS  |       | CITY  |                | STATE   |  | ZIP CODE   |                                |
| NAME OF EMPLOYER <input type="checkbox"/> Self Employed <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed   |       |   |                |   | WORK TELEPHONE<br>( )  |  |                                |
| ADDRESS OF EMPLOYER  |       | CITY  |                | STATE   |  | ZIP CODE   |                                |
| <p><b>AUTHORIZATION:</b> I hereby authorize any School, Participating Organization, Policyholder, trust, employer, insurance company, health plan, medical/dental provider or other person or entity to release any information/documentation needed to process this claim to Myers-Stevens &amp; Toohey Co., Inc. (MST) or its insuring company when requested by them to do so. This may include but is not limited to: details of the reported loss; identification of witnesses and supervisors; verification of other insurance or health coverage; coverage terms; explanations of benefits; complete health records including those involving mental/emotional disorders and substance abuse; prescription drug history and fully itemized bills in the form of CMS/HCFR 1500s and UB04s. If the claim is reportedly the result of participating in a School, Participating Organization or Policyholder activity, I authorize MST to share information concerning this claim as necessary with representatives of the School, Participating Organization or Policyholder as applicable. I understand that the authorization to release claim-related information/documentation to MST will terminate two years from the date of signature unless terminated in writing on an earlier date by me. A photo static/digital copy of this authorization shall be considered as valid and effective as the original.</p> |       |   |                |   |  |  |                                |
| NAME _____   |       | RELATIONSHIP TO CLAIMANT _____                  |                | SIGNATURE <b>X</b> _____  |  | DATE _____   |                                |
| <p><b>ASSIGNMENT OF BENEFITS:</b> I authorize the payment of benefits directly to the provider(s) of services and/or supplies associated with this claim.</p>  |       |   |                |   |  |  |                                |
| NAME _____   |       | RELATIONSHIP TO CLAIMANT _____                  |                | SIGNATURE <b>X</b> _____  |  | DATE _____   |                                |
| <p><b>FRAUD WARNING:</b> Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and/or civil penalties. I have read and acknowledge the General Fraud Warning above and the specific version for my state on the reverse side.</p>  |       |   |                |   |  |  |                                |
| NAME _____   |       | RELATIONSHIP TO CLAIMANT _____                  |                | SIGNATURE <b>X</b> _____  |  | DATE _____   |                                |

## STATE-SPECIFIC FRAUD WARNINGS

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

**Arizona:** For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas, Louisiana, Rhode Island, West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Hawaii:** For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

**Indiana:** Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Texas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

|   |  |
|---|--|
|  <p><b>Myers-Stevens &amp; Toohy Co., Inc.</b><br/>26101 Marguerite Parkway<br/>Mission Viejo, CA 92692-3203<br/>Office (800) 827-4695 • Fax (949) 348-9350<br/>claims@myers-stevens.com<br/>CA License #0425842</p> |  <p><b>First Health</b><sup>®</sup></p>                     |
| <p>Underwritten by: ACE American Insurance Company</p>   |  <p><b>First Choice Health</b></p> <p>PPO Network - WA</p> |